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Task Force to Study the Feasibility of Establishing Opioid Intervention Courts

January 1, 2019

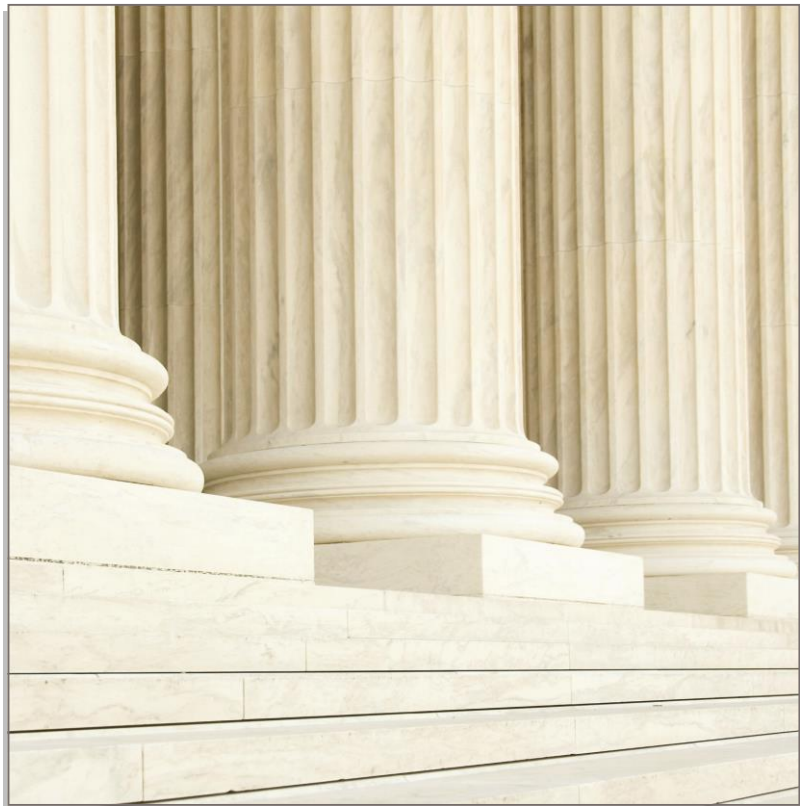


Table of Contents

Task Force Members	3
Executive Summary	4
Overview of the Study	5
Section I. Opioid Intervention Courts: A National Review	7
Section II. The Treatment Pathway Program	11
Section III. Criminal Justice System Responses to the Opioid Crisis: A Statewide Review	15
Section IV. An Examination of the Elements of An Opioid Intervention Court in Connecticut	20
Section V: Recommendations	22
Appendix A. Task Force Meeting Minutes	26
Appendix B. Presentation on Judicial Branch Contracted Services and the Treatment Pathway Program	33
Appendix C. Presentation by DMHAS on the Substance Use Service System	48
Appendix D. A National Review of Opioid Intervention Courts	61

Task Force Members

Hon. Patrick L. Carroll III, Chair
Chief Court Administrator

Hon. Joan K. Alexander
Chief Administrative Judge for Criminal Matters

Doreen Del Bianco
Deputy Director, Judicial Branch Division of External Affairs

Miriam E. Delphin-Rittmon, Ph.D.
Commissioner, Department of Mental Health and Addiction Services

Hon. Robert J. Devlin, Jr.
Assistant Administrative Judge

Lawrence D'Orsi II
Deputy Director, Superior Court Operations, Criminal Matters

Timothy Fisher, Esq.
Dean and Professor of Law, University of Connecticut School of Law

Michael Hines
Assistant Director, Program and Staff Development
Judicial Branch Court Support Services Division

Kevin T. Kane, Esq.
Chief States Attorney

Ivan Kuzyk
Director, Connecticut Statistical Analysis Center, Office of Policy and Management

Michael Norko, M.D.
Director, Forensic Services Division
Department of Mental Health and Addiction Services

Christine Rapillo, Esq.
Chief Public Defender

Gary A. Roberge
Executive Director, Judicial Branch's Court Support Services Division

Scott Semple
Commissioner, Department of Correction

Executive Summary

Introduction

Section 1 of Public Act 18-166, *AN ACT CONCERNING THE PREVENTION AND TREATMENT OF OPIOID DEPENDENCY AND OPIOID OVERDOSES IN THE STATE* required the Chief Court Administrator in consultation with the Chief Public Defender, the Chief State's Attorney and the Dean of the University of Connecticut School of Law to study the feasibility of establishing an opioid intervention court. The public act also required the Chief Court Administrator to submit a report on the findings of the study to the General Assembly's Judiciary Committee by January 1, 2019.

The following excerpt from the bill sets out this requirement in more detail:

Section 1. (Effective from passage) (a) The Chief Court Administrator or his or her designee, in consultation with the Chief Public Defender, Chief State's Attorney and the dean of The University of Connecticut School of Law, or their respective designees, shall study the feasibility of establishing one or more courts that specialize in the hearing of criminal or juvenile matters in which a defendant is an opioid-dependent person, who could benefit from intensive court monitoring and placement in a substance abuse treatment program.

(b) The study shall include an examination of: (1) The testing of certain arrestees for opioid use and the timing of such testing, (2) innovative and different treatment placement options for opioid-dependent arrestees, (3) the development of a rapid integration team of individuals who focus on meeting the treatment needs of opioid-dependent arrestees, (4) the development of judicial processes that include daily court monitoring of opioid-dependent arrestees, and (5) the use of curfews and electronic-monitoring tools as a means of facilitating success completion of a substance abuse treatment program.

(c) The Chief Court Administrator, or his or her designee, shall report on the results of such study to the joint standing committee of the General Assembly having cognizance of matters relating to the judiciary, in accordance with the provisions of section 11-4a of the general statutes, not later than January 1, 2019.

Overview of the Study

In accordance with the public act, the Chief Court Administrator convened a task force to study the matter. The members of the task force met on the following dates: September 18, 2018, October 17, 2018 and December 11, 2018, and heard presentations about:

1. The behavioral health services that the Judicial Branch, Court Support Services Division, provides to its clients;
2. These services include medication-assisted treatment (MAT), which, when used, in conjunction with behavioral therapy have proven effective in treating opioid use disorders.
3. The Judicial Branch's Treatment Pathway Program (TPP), which the Branch initiated in collaboration with the Department of Correction (DOC), Department of Mental Health and Addiction Services (DMHAS), the Division of Criminal Justice, the Division of Public Defender Services, and community-based treatment providers. This program treats non-violent offenders with substance use disorders;
4. The behavioral health services that DMHAS provides to residents of Connecticut; and
5. Opioid intervention courts nationwide.

During the presentations, it was clear that Connecticut has made great strides in addressing the opioid crisis, which the federal government has deemed a nationwide public health emergency.

Of particular note is that although the nation's first opioid intervention court, established in Buffalo, New York, in May 2017, may be successful, it is an intensive model that requires a significant judicial commitment.

A less resource-intensive approach that has shown success in Connecticut is the TPP, which redirects persons charged with less serious, non-violent drug or drug-related crimes, who have substance use disorders, and are held in lieu of bond, toward treatment and away from incarceration. Among the promising TPP outcomes is the successful treatment of participants with an opioid use disorder.

In addition to the presentations, the task force reviewed other ongoing initiatives among the state's criminal justice partners in responding to the opioid crisis.

Lastly, the public act required that the study examine certain elements of an opioid intervention court. Although these elements may be helpful in responding to a defendant with an opioid use disorder, some of the elements are already being utilized in different contexts, and implementing the elements in the judicial process would not only be duplicative, but would require significant resources.

Section I. Opioid Intervention Courts: A National Review

Introduction

Opioid intervention courts are a recent and experimental response to the national opioid crisis, which the federal government has deemed a nationwide public health emergency. The courts' focus on defendants who are at high-risk for an opioid overdose and are based on the drug court model of rehabilitating offenders, while at the same time teaching accountability. This model has been utilized for almost 30 years and, as of June 2015, it was estimated that there were over 3,000 such courts nationwide. This model is offender-based and includes the imposition of jail sanctions for positive drug tests, which may not be the best approach to address a public health issue.

The Buffalo Experiment

The first opioid intervention court was established in Buffalo, New York, in May 2017, funded, in part, by a three-year, \$300,000 grant from the Federal Bureau of Justice Assistance. The grant supports immediate, targeted, and intensive drug treatment services provided by physicians and case workers from the University at Buffalo's Family Medicine Addiction Clinic. The case managers provide behavioral therapy and counseling, enforce curfews, perform wellness checks, and transport participants to court appearances.

Participants, who are confined and non-violent, are screened by court staff for suitability before arraignment. Selection criteria include testing positive for opioids and being deemed at risk of overdose or addiction. Prosecution of the participants is temporarily delayed at arraignment, and the participants are linked to medication-assisted outpatient treatment for up to 90 days, with few exceptions, within 48 hours of arrest. Participants who successfully complete the program may have charges dismissed.

The program requires participants, who are released to outpatient treatment after arraignment, to undergo intensive monitoring by treatment case workers and to report to court each weekday for 90 days. During each court appearance, cases workers and court personnel screen participants for drug use and provide curfew compliance and home visit reports to the court. On weekends, court personnel monitor participants via telephone contact and occasional home visits.

After completion of the intensive phase of the program, a plea bargain is generally negotiated and the participant's case is continued for weekly court monitoring. At this time, some participants leave the program because a plea agreement could not be reached or the participant has already been sentenced.

In June 2018, during a meeting of the National Judicial Opioid Task Force, preliminary outcome data from the Buffalo Opioid Intervention Court was presented:

- 250 defendants have participated in the program;
- 138 are currently active;
- 109 have successfully completed the program; and
- 3 have completed the program, but have subsequently died from an overdose.

Members of Connecticut's task force noted that the Buffalo Opioid Intervention Court's requirement that defendants report to the court daily for 90 days was onerous and prevented defendants from seeking employment and fully re-engaging in their community life. The members also commented that the model was offender-based as opposed to a public health model. Additionally, members expressed concern over the costs and resources associated with this model. In fact, in a review of this program, New York State Chief Judge Janet DiFiore has cautioned that:

The Buffalo Opioid Intervention Court reflects a resource-intensive approach that may be hard for some jurisdictions to replicate given the many behavioral health

*and court personnel required to manage and execute the multiple aspects of the program.*¹

Other Interventions

A model of similar intensity to the Buffalo City intervention was established in Cumberland County, Pennsylvania, in February 2018, but as of this writing, no data was available for review.

The court system in Bronx County, New York, began a less intensive approach in December 2017. With this program, defendants charged with a specific misdemeanor drug possession charge and at high-risk for opioid overdose are diverted to a specialized case track, the Overdose Avoidance and Recovery Track.

This track offers intensive treatment in lieu of incarceration, and successful completion of the track results in the case being dismissed. Defendants also may be subject to community supervision and, in addition to treatment, are linked to services such as job training and housing by Bronx Community Solutions, a public/private partnership initiative already present at the court. This intervention differs from the Buffalo City model in that it utilizes resources already in place. As of September 2018, 35 participants have completed the program, and there are plans to consider increasing the number of charges eligible for the program and to expand the model throughout New York City.

In August 2018, Suffolk County, New York, launched an intervention program, similar to the Bronx County model, to address the opioid crisis. This program, the Comprehensive Addiction Recovery and Education program, targets non-violent first-time offenders and non-violent offenders with a minimal criminal history who are

¹ National Center for State Courts, New York State's Opioid Intervention Court, (2018): 4

charged with drug-related misdemeanors. As with the Bronx County model, the charges are dismissed if the participant successfully completes the program. The program is designed not to exceed a 90-day treatment plan that is tailored to the participant's needs and uses existing court resources.

Section II. The Treatment Pathway Program

Introduction

In response to the opioid crisis, the Judicial Branch, in collaboration with the DOC, DMHAS, the Division of Criminal Justice, the Division of Public Defender Services, and community-based treatment providers, initiated the Treatment Pathway Program (TPP). The objectives of the program are to:

1. Redirect persons charged with less serious, non-violent drug or drug-related crimes, who have substance use disorders, and held in lieu of bond, toward treatment and away from incarceration;
2. Provide a meaningful treatment opportunity to defendants with substance abuse disorders and may have little or no access to treatment in the community; and
3. Reduce the incarcerated population.

Process

The Judicial Branch developed the TPP process over a six month period during meetings with stakeholders including a community provider, Recovery Network of Programs, which committed to same day treatment admissions for participants. As part of this process, intervention begins at the defendant's initial detention and/or court hearing, otherwise known as the Intercept 2 stage of the Sequential Intercept Model. This model is a best practice for targeting strategies to treat justice-involved persons with behavioral health disorders.

The Judicial Branch piloted TPP in 2015 at Bridgeport Superior Court with \$100,000 grant from the Public Welfare Foundation and technical assistance from the Treatment Alternatives for Safe Communities. The funding supported a licensed clinical social worker who is housed in a licensed "clinic" in the courthouse; this licensing of a space

in the courthouse is important for sustainability because it allows for third party billing of behavioral health services performed at the courthouse. In addition, the grant supported data collection and analysis.

Components of the TPP process include:

1. Judicial Branch, Bail Services staff screen detained defendants for initial appropriateness for the program.
2. The program is voluntary and defendants must want to seek treatment to address the substance use disorder. If defendants choose not to seek treatment, they are not enrolled in the TPP.
3. If initially found eligible, the defendant is referred by Bail Services staff to the court-based TPP clinician for assessment.
4. During the assessment, the clinician conducts a clinical and risk screening.
5. After the assessment, Bail Services staff and the provider meet to determine appropriateness for the program.
6. If the defendant is determined to be eligible, Bail Services staff will recommend to the court that the individual be placed in the program. The recommendation includes a proposed service plan for the defendant.
7. If the court grants the program, the defendant is released from custody and meets with the clinician for linkage to treatment and other services.
8. While the case is pending, Bail Services staff and the provider work collaboratively to monitor the defendant's compliance and treatment progress. At each hearing date, Bail Services staff provide a progress report to the court.

TPP services include:

1. Substance use and mental disorder treatment and support services;
2. Medication-assisted treatment (MAT), which is commonly used to treat opioid addiction. Such treatment may include:
 - a. Methadone, a daily liquid, which can be provided only in specialty regulated clinics.
 - b. Naltrexone, a daily pill or monthly injection, which can be provided in a regular care setting.
 - c. Buprenorphine, a daily dissolving tablet, cheek film, or six-month implant under the skin, which can be provided by a qualified provider in a regular care setting
3. Housing assistance;
4. Entitlement enrollment;
5. Access to medical care;
6. Access to employment services;
7. Access to social supports; and
8. Access to peer support.

During the initial stage of the pilot, judges in Bridgeport heard from one TPP participant who described how the program has changed his life. He is now working and reconnected to his family after many years of being estranged. There continues to be a careful program review to determine outcomes.

Program Expansion

Since TPP's inception in 2015, the program has been expanded to the New London and Torrington Geographical Courts in 2017 and to the Waterbury Geographical Court in July 2018. This expansion has been funded in part by federal grants awarded to DMHAS, and through third party behavioral health treatment services reimbursement. The cost of the program at each location is \$100,000, and Bridgeport has covered that cost through reimbursements from Medicaid and third-party insurance companies.

Summary of Outcomes

1. Those using MAT had a 73% completion rate compared with a completion rate of 45% of those who did not.
2. Less than 25% of TPP clients whose pending case(s) was disposed of received a sentence that included a term of incarceration.
3. Significantly, 75% of defendants referred to TPP received treatment on the day of their arraignment. This is a key component of the program.
4. The Bridgeport TPP is self-sufficient.
5. Defendants with substance use disorders are generally at higher risk of failing to appear and re-arrest than the overall pre-trial population. Participation in TPP reduces this disparity.

Estimated Cost Savings

Since the inception of the program, if the TPP participants who were not incarcerated as a result of their participation in the program were to have been incarcerated, it is

estimated that it would have cost over \$9 million dollars to incarcerate these participants (based on a daily cost of incarceration of \$129).

Section III. Criminal Justice System Responses to the Opioid Crisis: A Statewide Review

Department of Mental Health and Addiction Services

There is an extensive system of substance use treatment programs throughout the state. In FY 18, there were over 65,000 admissions to licensed substance use treatment programs in Connecticut. More than 58,000 individuals made use of these substance use services. The type and number of beds are represented in the DMHAS PowerPoint presentation, slide #2 (see Appendix C). The utilization of these beds is typically 88-98 percent. DMHAS maintains an online real-time registry of available detox and rehab beds at <http://www.ctaddictionservices.com>

In Connecticut, to some degree, every court serves the role of an opioid court. Though they vary according to population and funding, every town in which there is a Geographical Area court has at least one substance use treatment program, and often more than one. This distribution is mapped on DMHAS slide # 8, and listed in table form on DMHAS slides #16 & 17. There are substance use walk-in assessment centers distributed throughout the state, as in DMHAS slide #9. The addresses, phone numbers and service hours are listed on the DMHAS website noted on that slide. We are also fortunate to have licensed medication-assisted treatment (MAT) programs across the state, as displayed on DMHAS slide #10. The details for each of these MAT programs may be accessed on an online interactive map available at:

https://public.tableau.com/views/CTBHPMedicaidMATProviderMap/TreatmentProviders?:embed=y&:display_count=yes&:showVizHome=no

Connecticut has received federal grant money for programs responding to the opioid epidemic. The first was the Substance Abuse Mental Health Services Administration (SAMHSA) State Targeted Response Opioid Grant. The current grant is the SAMHSA State Opioid Response (SOR) grant, which provides \$22.2 million in fiscal years 19 and 20. Support for three of the four TPP operated by the Judicial Branch comes from this grant. The grant also supports for:

- The Law Enforcement Assisted Diversion (LEAD) initiatives in Hartford and New Haven, which allow police officers to divert low-level drug offenders to community services rather than being arrested;
- Methadone maintenance and MAT induction at DOC facilities;
- DOC's Re-entry Support Program, which involves extensive in-reach pre-release, followed by treatment post-release in New Britain and Bristol; and
- A redesigned program for women entitled, "Recovery, Engagement, Access, Coaching and Healing" (REACH), provides substance recovery coaching and case management services throughout the state.

In addition to the recovery coaching offered to women as part of the REACH program, DMHAS funds recovery coaches in collaboration with the Connecticut Community for Addiction Recovery and eight hospitals in the state. These recovery coaches - who are recovering from substance use disorders and have undergone specialized training - assist persons admitted with opioid overdose and other alcohol and/or drug-related medical emergencies. Recovery coaches also connect these individuals with substance use disorder treatment and services and provided resources and support to their families. This program is based on initiatives in other New England states where recovery coaches have demonstrated effectiveness in linking emergency department patients with substance use disorder treatment and community-based recovery

resources. DMHAS also has been successful in connecting recovery coaches with MAT patients.

A fact sheet listing all the services provided through the SAMSHA SOR grant is available at <https://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=605088>

Key Points:

- Connecticut is fortunate to have substance use programs distributed throughout the state, including MAT for opioid use disorders.
- Treatment diversion services are already available in every court.
- The SAMHSA SOR grant will continue to support programs serving the criminal justice system as well as communities.
- Opportunities for further development include expansion of existing services, like TPP, and seeking means to sustain programs developed through federal grants.

The Division of Public Defender Services

The Division of Public Defender Services currently employs 33 full-time social workers covering offices and specialized units across the state. The social workers assess and identify if a client is impaired by mental illness, cognitive deficits, and medical or substance abuse issues. In addition, they determine if any impairments contributed to the arrest and seek treatment options as an alternative to incarceration.

Treatment could include therapy, counseling and referrals for basic needs such as food and housing. When a client is referred to a specific program, a social worker will participate in treatment planning and ensure that the delivery of services best suits the client's needs. The social workers are knowledgeable about programs available within their court jurisdiction and have relationships with evaluators and providers. They are

familiar with the families and clients and are able to provide support that enhances the opportunity for the client to leave the criminal justice system healthier and more successful in their community.

Regrettably, recent budget cuts have depleted these social worker ranks. There are no longer full time social workers in many offices, leaving clients with no services on a given day. This is especially harmful to clients who present at arraignment with an addiction that led to or contributed to their arrest. It should be noted as well that many clients will initially not qualify for a pretrial diversion program, and an immediate intervention by the public defender social workers can ameliorate problems and help a client become eligible for these programs.

The Judicial Branch, Court Support Services Division

The Judicial Branch, Court Support Services Division contracts with 35 licensed outpatient adult behavioral health services clinics across the state to provide treatment services to clients. These services include diagnosis of and treatment for substance use and mental disorders. In addition, all of these programs provide some form of MAT.

Prior to fiscal year 2014-2015, the Judicial Branch had access to 15 residential treatment programs for a total of 311 slots, through a Memorandum of Agreement with DMHAS. Unfortunately, due to budget cuts in fiscal year 2015-2016, the number of residential treatment slots has been reduced by 123. The loss of these 123 residential treatment beds has negatively impacted the Branch's ability to service both pretrial and probation clients with significant substance abuse issues, including opioid dependency. Though the average varies daily, roughly 66% of all clients in the Judicial Branch's residential treatment beds are pretrial incarcerated men and women with a pending case. That means approximately 81 more defendants would be in treatment today if those beds were still available. With an average length of stay of 90 days, it would equate to an additional 324 incarcerated defendants receiving drug treatment services in the community annually.

The remaining 33 percent, or 42 beds, is utilized by probationers as an alternative to violation of probation or a court ordered condition. A majority of these clients face incarceration should they fail this residential placement. With an average length of stay of 90 days, this would mean an additional 168 bail and probation clients could receive residential treatment annually.

Department of Correction

The DOC provides medication-assisted treatment, specifically methadone, to inmates with opioid disorders in six of its facilities. This program initially treated with methadone inmates who had been receiving methadone in the community prior to incarceration. It has since been expanded to provide methadone induction to inmates discharging from DOC who are at risk for overdose.

In addition to the methadone programming, DOC collaborates with DMHAS and the Yale School of Medicine on a reentry initiative “Living Free.” This program provides treatment services for inmates discharging to the New Haven area and who have substance, including opioid, use and co-occurring disorders. The treatment is provided through the Forensic Drug Diversion Clinic in New Haven and funded by a federal grant. This program begins providing services to the inmates before they are released and continues through their re-entry into the community.

Section IV. An Examination of the Elements of An Opioid Intervention Court in Connecticut

A component of the task force's charge was to review the following elements of an opioid intervention court:

1. The testing of certain arrestees for opioid use and the timing of such testing.

The testing of certain arrestees for opioid use can be accomplished by Judicial Branch staff before arraignment. However, there would be significant challenges such as: The cost of the test, finding staff available to conduct the testing and locating an appropriate facility to complete the analysis.

2. Innovative and different treatment placement options for opioid-dependent arrestees.

Connecticut currently offers a number of innovative and different treatment placement options for opioid-dependent arrestees as set forth in Sections II. and III. of this report.

3. The development of a rapid integration team of individuals who focus on meeting the treatment needs of opioid-dependent arrestees.

Connecticut currently has comparable teams that are readily available as discussed further in Sections II. and III. of this report.

4. The development of judicial processes that include daily court monitoring of opioid-dependent arrestees.

While this model would allow the court to be apprised daily of the arrestees' progress and impose immediate sanctions for noncompliance, requiring defendants to appear in court daily disrupts the defendant's ability to seek employment and to re-engage in community life. Additionally, this process

would require a substantial use of court resources, and may be unnecessary to promote the arrestees' success as evidenced by the TPP. (See Sections II. and III. of this report.)

5. The use of curfews and electronic-monitoring tools as a means of facilitating successful completion of a substance abuse treatment program.

If placing restrictions on defendants such as curfews would promote success, then the Judicial Branch could add this component to the TPP. This monitoring would allow the court to be aware of the arrestees' activities outside of court and impose sanctions as needed. With current staffing levels, however, it would be challenging to find staff available to conduct the monitoring.

Section V: Recommendations

The task force members strongly believe that the opioid crisis should be treated foremost as a public health problem and that tethering treatment too much to the court process may be counterproductive. In many cases, the best opioid court is not court at all; entanglement in the criminal justice system, particularly for low-level offenders, can be less productive than diversion. The members also agree that combatting the crisis can best be achieved by expanding existing programs rather than by creating specific opioid intervention courts, which are staff and resource intensive, and will not reach as many people.

The task force members concluded that it would not be prudent to establish one or more opioid intervention courts in Connecticut for a number of reasons. First, such a court would be labor intensive and very expensive.² Second, there is no indication that defendants who participate in an intensive court-based monitoring program are more likely to sustain recovery than those who participate in the TPP program. Third, establishing a limited number of opioid intervention courts would leave those defendants with similar cases in other judicial districts without this option.

After considering all of the information presented, the task force members recommend the following in order of priority:

Recommendation Priority #1: Expand the TPP statewide

The TPP program is currently operational in four court locations, Bridgeport, New London, Torrington and Waterbury, and DMHAS funds a similar program in Hartford called the Jail Diversion Substance Abuse Program. The annual cost of TPP is \$100,000

² Janet DiFiore, Chief Judge for the State of New York, noted that the Buffalo Opioid Intervention court “reflects a resource-intensive approach that may be hard for some jurisdictions to replicate given the many behavioral health and court personnel required to manage and execute the multiple aspects of the program.”²

in each location and that cost can be met through third party treatment reimbursement if the volume of participants reaches a certain level. Currently, Bridgeport has reached financial sustainability, but the other locations are still supported by federal funding. It is important to note that the federal funds lapse in July of 2020.

The task force members recommend that the TPP be expanded statewide. It is estimated that such an expansion would cost \$1.8 million and would take 12 months to roll out. (Please note that this cost includes the funds necessary to continue to operate the TPP in New London, Waterbury and Torrington, when the federal funds lapse.) Additionally, expanding the program to courts throughout the state would increase access to eligible participants, increasing the number of arrestees diverted from incarceration to treatment, and potentially saving the state millions of dollars based upon the current daily rate of incarceration. The cost to operate the TPP program statewide would be realized in the costs saved from incarceration alone.

Recommendation Priority #2: Provide funding to the Division of Public Defender Services for two additional social workers

The task force recommends that more funding be allocated to the Division of Public Defender Services to pilot two new social worker positions in New London and Torrington, two of the jurisdictions hardest hit by the opioid crisis. These social workers would:

- Provide enhanced case oversight to assist clients referred to existing programs such as TPP;
- Review cases of individuals who were found ineligible for TPP or another CSSD programs to assess if circumstances leading to the denial could be addressed so the client could participate in the program;

- Assess the needs of clients who have been denied court supported treatment services and attempt to locate and engage appropriate interventions to support recovery and compliance with court supervision orders;
- Identify clients with children and coordinate interventions for those who are dually involved in the criminal and child welfare systems. The social workers would provide more intense follow up and support to help clients navigate the service provider system. The social workers would also coordinate activity among the multiple lawyers working with the clients to ensure that all systems are working toward outcomes that support reintegration and overall community improvement.

The starting salary for a social worker is \$53,202, so the total annual cost of two social workers would be \$106,404.

Recommendation Priority #3: Contract for an additional 123 residential beds for defendants not eligible for TPP

Due to budgetary constraints in fiscal year 2015-2016, the Judicial Branch reduced the number of residential treatment beds by 123. The loss of 123 residential treatment beds has negatively impacted the Branch's ability to service both pretrial and probation clients with significant substance abuse issues, including opioid dependency

The cost per bed through the Judicial Branch's existing collaborative with DMHAS varies from program to program depending on the level of care; based on the previous 123 - bed reduction, it is estimated that the average cost per bed would be \$38,000 to \$58,000. The task force members recommend reinvesting in the DMHAS collaborative to re-purchase these beds. The total cost to implement this recommendation would be between \$4,674,000 and \$7,134,000.

Recommendation Priority #4: Early Screening and Intervention (ESI) Pilot Program

The Division of Criminal Justice established its first ESI units in the Geographical Area courts serving Bridgeport and Waterbury in May of 2017 with the goal of vetting cases involving low level offenses. The cases are assessed for factors such as substance abuse, including opioid addiction, mental illness and personal circumstances, and this information is used to appropriately charge, or dispose of the case.

With the passage of P.A. 17-205, the General Assembly required the Division to set up similar pilot programs in Hartford, New Haven, New London and Norwich.

As of September 30, 2018, 9,634 cases had been reviewed, with 1,323 being diverted into programs involving drug and mental health counseling, job and housing assistance and Accelerated Rehabilitation. Additionally, there were 885 nolle prosequis and 490 dismissals, with 88.24% of all dispositions achieved with 2 or fewer appearances before a judge.

Expanded to statewide, this program could annually divert more than 6,200 cases with more than 5,700 requiring 2 or fewer appearances before a judge. The Division of Criminal Justice is currently developing a report regarding this pilot program to be submitted to General Assembly on February 1, 2019. Task Force recommends that the General Assembly thoroughly examine this report to determine how the ESI program might be expanded.

Section VI: Conclusion

In conclusion, the task force believes strongly that Connecticut is well-suited to respond to this public health crisis, but that the answer doesn't just reside with the courts.

Rather, the solution is a multi-pronged approach that will save lives and help these individuals get back on track and lead productive lives. For this reason, the task force urges the legislature to fund its three recommendations rather than funding the labor and resource-intensive opioid intervention courts.

The task force is grateful to all of the contributors to this report and stands ready to respond to any questions from the members of the General Assembly.

Appendix A. Task Force Meeting Minutes

The Task Force met on the following dates: September 18, 2018, October 17, 2018 and December 11, 2018. The minutes of the meetings are included in this appendix.

Minutes

Connecticut Judicial Branch Task Force to Study the Feasibility of Establishing Opioid Intervention Courts

Meeting of Tuesday, September 18, 2018 at 10:00 a.m.

**Litchfield Judicial District Courthouse at Torrington
Courtroom C3
50 Field Street, Torrington, CT**

Members in attendance: Judge Patrick Carroll, III, Chair; Judge Joan K. Alexander; Judge Elizabeth Bozzuto; Doreen Del Bianco; Judge Robert J. Devlin, Jr.; Lawrence D’Orsi, II; Dean Timothy Fisher; Michael Hines; Atty. Kevin T. Kane; Ivan Kuzyk; Dr. Michael Norko; Atty. Christine Rapillo; Gary A. Roberge; Commissioner Scott Semple. Staff present: Atty. Matthew Berardino.

I. Welcome and Introductions

Judge Carroll convened the meeting at 9:58 a.m., and welcomed the committee. The members of the committee introduced themselves.

II. Charge of Committee

Judge Carroll discussed the background of the opioid crisis in Connecticut as a public health issue, and described the committee’s charge pursuant to Section 1 of Public Act 18-166, and requirement to report to the General Assembly by January 1, 2019.

III. Overview of current programs designed to assist substance-dependent defendants

Gary Roberge and Michael Hines from Court Support Services Division presented a slide show to the Task Force about the current programs available.

Gary Roberge began the presentation with information about Judicial Branch contracted services, including Alternative in the Community (AIC), Adult Behavioral Health Services, Medication Assisted Treatment Options, and Residential Services.

Judge Carroll commented that many services that CSSD offers are statewide, rather than limited to a specific court location.

Mike Hines continued the presentation with information about the Treatment Pathways Program (TPP), including how the program is sustained, site selection in Bridgeport (2015), New London (2017), Torrington (2017) and Waterbury (2018) based on data from the Department of Mental Health and Addiction Services (DMHAS), a discussion of demographics, levels of care and success metrics. He noted the accessibility of the program, with 75% admitted within one day.

Judge Carroll inquired about what would be necessary to expand TPP to other districts, and Mike Hines responded that the program would need to be sustained from a number of sources (federal, state, municipal, Substance Abuse and Mental Health Services Administration (SAMSA) grants for clinicians, Medicaid). More outside funding would be needed in lower volume districts. The City of Bristol has expressed interest in the program, and obtaining funding from private donors. Mike Hines also noted that it would be more cost effective to expand TPP than to set up individual drug dockets throughout the state.

IV. Discussion and Next Steps

Ivan Kuzyk noted that over 50% of opioid deaths in the last two years have been people with a Department of Correction (DOC) number.

Judge Devlin noted that a financially self-sustaining program is ideal, but that tax payers may need to supplement.

Christine Rapillo mentioned the need for more social workers in the Public Defenders' offices, and the difficulty of travel for many clients.

Commissioner Semple and Mike Hines discussed what has been done in other states, with Mike Hines noting that there is an opioid court in Buffalo, but that is not a statewide program.

Judge Carroll noted that Connecticut has the advantage of being a small state with a unified court system, allowing it to more readily address the crisis on a statewide basis, unlike other states.

Kevin Kane discussed the benefits and necessity of intervening earlier in an individual's contact with the system; the earlier the diversion, the better.

Dean Fisher noted the success Rhode Island has had with a medication assisted treatment program, and Commissioner Semple agreed.

Judge Carroll stated that the Task Force's next meeting will be on October 17, 2018, and that Dr. Miriam Delphin-Rittmon, Commissioner of DMHAS, will provide an overview of DMHAS services. The Task Force will also examine information from other states.

Judge Carroll also noted the goal of the Task Force to provide a draft of the report before the November 5 meeting, and make that draft available online.

V. Adjournment

The Task Force adjourned at 11:10 a.m.

Draft Minutes

Connecticut Judicial Branch Task Force to Study the Feasibility of Establishing Opioid Intervention Courts

Meeting of Wednesday, October 17, 2018 at 10:00 a.m.

**Litchfield Judicial District Courthouse at Torrington
Courtroom C3
50 Field Street, Torrington, CT**

Members in attendance: Judge Patrick Carroll, III, Chair; Judge Joan K. Alexander; Judge Elizabeth Bozzuto; Doreen Del Bianco; Dr. Miriam E. Delphin-Rittmon; Judge Robert J. Devlin, Jr.; Lawrence D'Orsi, II; Dean Timothy Fisher; Michael Hines; Ivan Kuzyk; Dr. Michael Norko; Atty. Christine Rapillo; Gary A. Roberge.

Atty. Brian Austin appeared on behalf of Atty. Kevin T. Kane; Dr. Kathleen Maurer appeared on behalf of Commissioner Scott Semple.

Members absent: Judge Elizabeth Bozzuto.

Staff present: Atty. Matthew Berardino.

I. Welcome and Introductions

Judge Carroll convened the meeting at 10:05 a.m.

II. Approval of minutes from the last meeting held on September 18, 2018

Judge Carroll entertained a motion to approve the minutes from the last meeting. The motion was made and seconded. The Task Force approved the minutes by voice vote.

III. Overview of current programs provided by the Department of Mental Health and Addiction Services (DMHAS)

Dr. Delphin-Rittmon presented a slideshow to the Task Force about the current programs DMHAS has for individuals addicted to opioids.

Following the slideshow, Judge Carroll commented on the importance of getting the word out about the DMHAS programs, and asked Dr. Delphin-Rittmon how many, of the 65,000 participants DMHAS has seen, came to them through the criminal justice system.

Dr. Delphin-Rittmon stated that DMHAS can investigate that number.

Dr. Maurer stated that the number is less than one might think, but that there are data issues around this, and linking individuals from the Department of Correction (DOC) to DMHAS programs following their reentry.

Judge Carroll and Dr. Maurer emphasized that the opioid crisis is a public health crisis foremost, in addition to a criminal justice issue, and that it must be addressed at many levels of society, specifically with options that keep people out of the criminal justice system in the first place.

Dr. Delphin-Rittmon noted the efforts of the Alcohol and Drug Policy Council to take a multiagency and community approach to the issue.

Doreen Del Bianco asked about the Law Enforcement Assisted Diversion (LEAD) program.

Dr. Delphin-Rittmon explained that the program is in Hartford and New Haven, and enables law enforcement to refer individuals who are suffering from an addiction who come in contact with police to a DMHAS program, as opposed to arresting them.

Dean Fisher inquired whether any of the grant money that has been available has included money to examine cost effectiveness of the programs, and Dr. Delphin-Rittmon stated that 10 to 15 percent has been for this purpose. Dr. Delphin-Rittmon also stated that this data has been the impetus for some federal legislation.

Dr. Maurer and Dr. Delphin-Rittmon discussed the financial sustainability of the programs, and that DOC depends on DMHAS for its in-facility programs. Dr. Delphin-Rittmon noted that Medication Assisted Treatment (MAT) can be funded through Medicaid, but not in a corrections setting.

IV. Overview of opioid court measures taken by other states

Mike Hines presented a slideshow to the Task Force about opioid courts in other states, primarily focusing on Buffalo, NY, the Bronx, and Cumberland County, PA.

Judge Carroll noted that Mike Hines, Dr. Kathleen Maurer and Judge Devlin will discuss Connecticut's programs at the New England Regional Conference of Criminal Justice, as there has been interest from other states in this model.

Gary Roberge asked if there was recidivism data from Buffalo, and Mike Hines responded that the court was only formed in 2017, so it is too recent to have that data.

Christine Rapillo noted that it can be counterproductive for defendants to appear too often at court, and asked if there is outcome data from the regular docket in Buffalo to

compare. Mike Hines stated that there is not much data available from Buffalo, but that it is difficult to get people to return to court frequently.

Atty. Rapillo noted that there are constitutional and due process issues with the Buffalo model.

Judge Devlin asked if the defendants at the Buffalo court appear before a judge every day, and Mike Hines responded that they do.

Judge Devlin stated that in looking at the opioid issue from a public health perspective, it is necessary to uncouple a person's addiction from their court case, which is accomplished by Connecticut's Treatment Pathways Program (TPP).

Dr. Maurer agreed that TPP is more primarily a healthcare program, that multiple court appearances can needlessly punish and that it must be recognized that relapse is a part of the recovery process.

V. Discussion and next steps

Judge Carroll stated that the Task Force's next step is to prepare a draft of its report, but that input is needed from everyone at the table. Task Force members are to submit concepts, and once a draft is put together, it will be posted on the Task Force's webpage for public comment.

VI. Adjournment

The Task Force adjourned at 11:10 a.m.

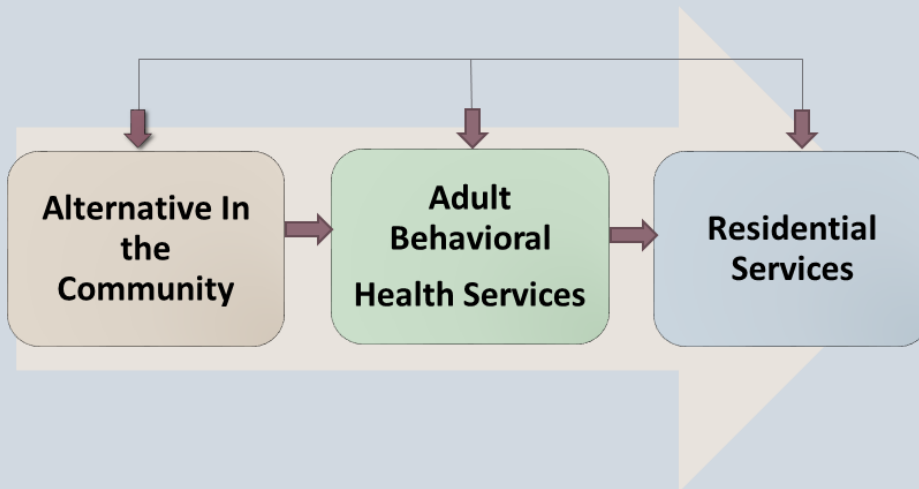
Appendix B. Presentation on Judicial Branch Contracted Services and the Treatment Pathway Program



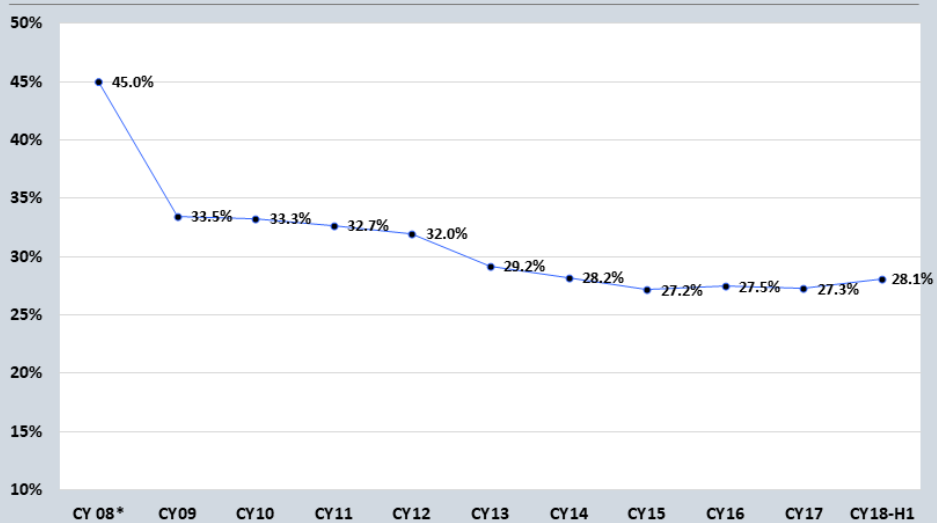
Task Force to Study the Feasibility of Establishing Opioid Intervention Courts

September 18, 2018

Judicial Branch Contracted Services



AIC Recidivism Rate



Adult Behavioral Health Services (ABHS)

Judicial Branch, Court Support Services Division

currently contracts with 35 licensed outpatient clinics located across the State of CT.

ABHS Clinics evaluate, diagnosis and treat substance use disorders, mental health and trauma disorders, and anger management.

Clinics use evidence-based or research driven clinical interventions including cognitive behavioral treatment.

Treatment is gender responsive and gender separate.

ABHS Contracted Services

Care Coordinator(s) is funded in every ABHS clinic. Responsibilities include: client engagement, enhanced communication and coordination, and required reporting to CSSD staff.

Integrated Substance Abuse and Mental Health Evaluations: Clinical staff evaluate individuals to determine if a substance or mental health diagnosis is present, and place individual in the appropriate level of care based on the evaluation.

ABHS Contracted Services (Cont.)

Individual and Group Treatment includes: Substance use, co-occurring, mental health, anger management, trauma and relapse prevention. Group treatment is generally 60 – 90 minutes, one time a week for 12 weeks.

Intensive Out-Patient Treatment (IOP): Intensive substance use or co-occurring treatment for individuals with chronic substance use or co-occurring disorders but do not meet clinical criteria for inpatient treatment. Treatment includes group, and individual counseling. IOP is 3 hours a day, 3 times a week for 4 to 6 weeks, based on the client's individual needs.

ABHS Contracted Services (Cont.)

Medication Evaluations and Medication Management: Medication evaluations are conducted by a Doctor or Advanced Practice Registered Nurse to determine if medication is required to treat the mental health or substance use disorder. Medication is regularly monitored for dosage, side effects and effectiveness.

Substance Use Testing: Urines and breathalyzers are taken when ordered to detect the use of alcohol and/or drugs.

Adult Behavioral Health Services Referrals by Year

2009	2010	2011	2012	2013	2014	2015	2016	2017
14,135	17,845	19,408	19,879	20,135	20,104	20,434	20,829	19,851
Aggregated Data Collection (ABCD)			Client – Level Data Collection (CDCS)					

12- Month New Arrest Rate for Program Completers, by Calendar Year

2009	2010	2011	2012	2013	2014	2015	2016	2017
			27.8%	28.4%	25.4%	24.3%	23.1%	24.4%
No Data Available			Client – Level Data Collection (CDCS)					

Medication Assisted Treatment in JBCSSD ABHS contractors

Methadone

Buprenorphine / Suboxone

Vivitrol

Naltrexone

31 of 35 locations will write a prescription for Naloxone (Narcan) for opioid users.

Medication Assisted Treatment Options

Of the 35 Clinic's:

- 1 agency offers all 4 MAT
- 14 agencies offer 3 MAT
- 11 agencies 2 offer MAT
- 8 agencies offer 1 MAT
- 1 agency is in process of offering MAT
- Several agencies are in process of adding an additional MAT

Residential Drug Treatment

Access to 188 residential treatment beds through an MOA with the Department of Mental Health and Addiction Services (DMHAS).

Services and length of stay vary from program to program depending on their duration and level of care, but include 20 or more hours of group treatment a week, comprehensive case management, life skills, employment readiness, family therapy to name a few.

Population served – male and female 18 years of age and older with significant substance abuse and minor co-occurring mental health disorders.

Residential Drug Treatment cont.

Programs accept Judicial Branch referrals state-wide.

Programs provide monthly probation updates and court reports for pretrial defendants.

Recently, to combat the opioid epidemic, 8 of the 9 programs in the collaborative with DHMAS have begun to accept clients currently on Medication Assisted Treatment.

Several of the programs have begun the process to begin dispensing MAT in house.

Residential Drug Treatment cont.

Providers:

- APT Foundation – New Haven
- Help Inc. – Waterbury
- SCADD – Lebanon
- McCall Foundation – Torrington
- Liberation Programs – Stamford
- CHR – Putnam
- CT Renaissance West – Waterbury
- Wellmore – Waterbury
- Perception Programs – Willimantic

Adult Residential DMHAS Admissions

Provider	Adult Probation	Bail	Family	Grand Total
DMHAS – APT (Amethyst), New Haven	3	9		12
DMHAS – APT Foundation, Inc., Bridgeport	13	26		39
DMHAS – APT, New Haven	85	152		237
DMHAS – Help, Waterbury	10	49		59
DMHAS – Lebanon Pines, Lebanon	31	36		67
DMHAS – Liberation, Stamford	19	58		77
DMHAS – McCall, Torrington	4	20		24
DMHAS – Milestone, Putnam	14	13		27
DMHAS – Perception, Willimantic	5	30		35
DMHAS – Ren. West, Waterbury	82	148		230
DMHAS – Wellmore, Waterbury	15	12		27
DMHAS – Farrell, New Britain	11	4	1	16
Grand Total	292	557	1	850



Treatment Pathway Program

Treatment Pathway Program Locations

Bridgeport Superior Court

- June, 2015

New London Superior Court

- October, 2017

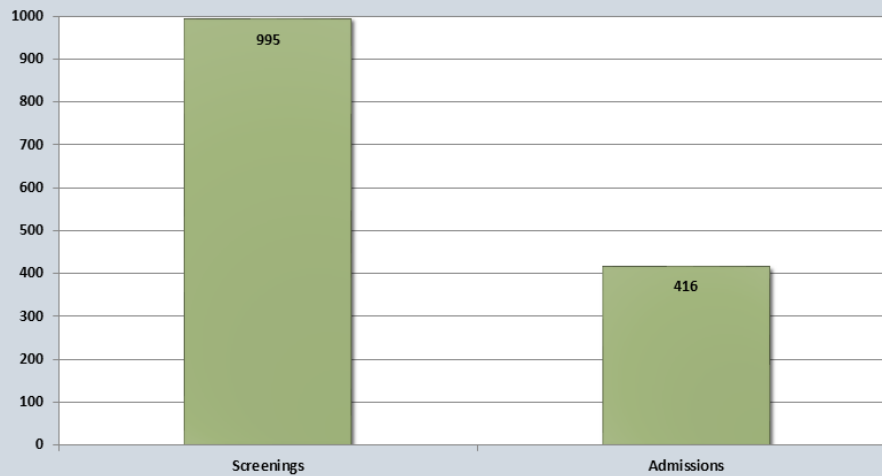
Torrington Superior Court

- October, 2017

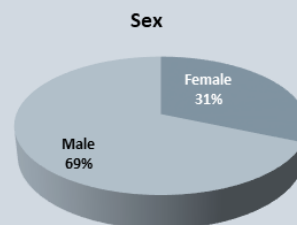
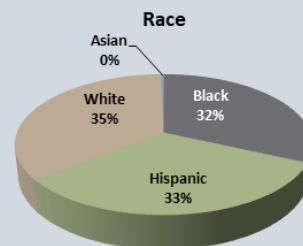
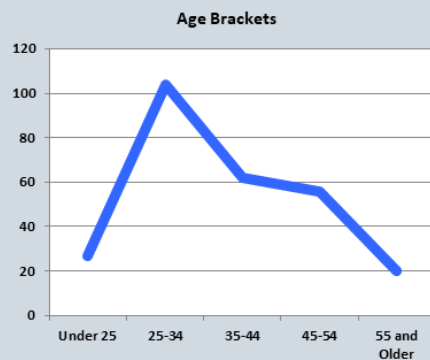
Waterbury Superior Court

- July, 2018

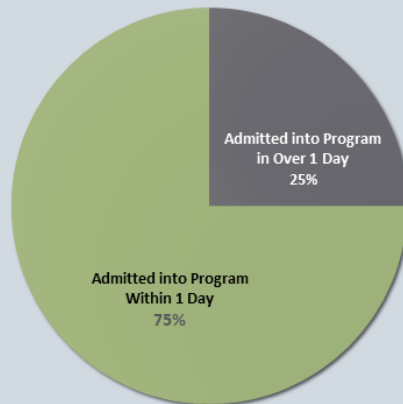
TPP Screenings & Admissions



Demographics

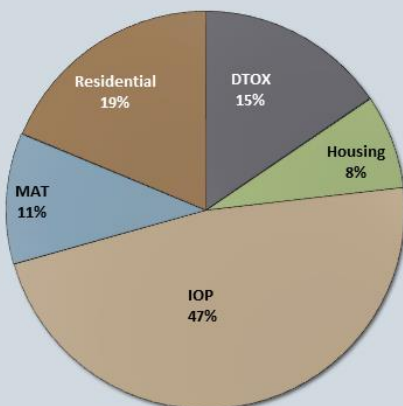


Accessibility to Treatment



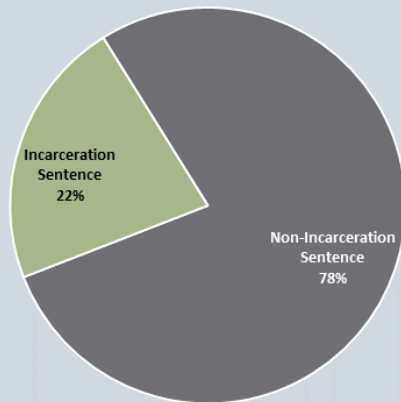
RNP – MCCA Data

Initial Admissions by Level of Care



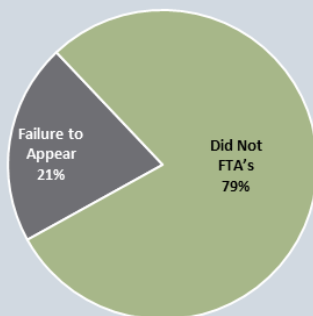
RNP – MCCA Data

Disposed TPP Clients

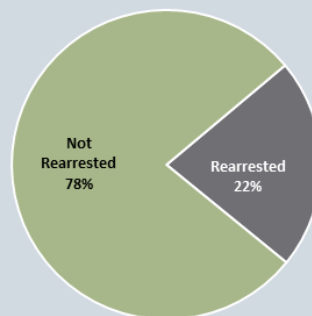


Failure to Appear & Rearrests

Failure to Appear

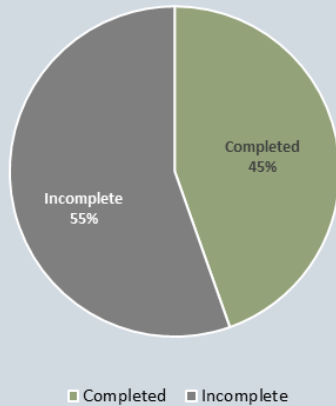


Rearrests

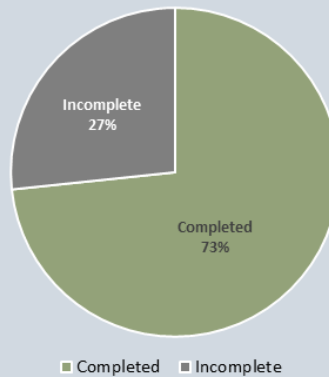


Clients With Primary Diagnosis of Opiate Dependence

No Medication Assisted Treatment

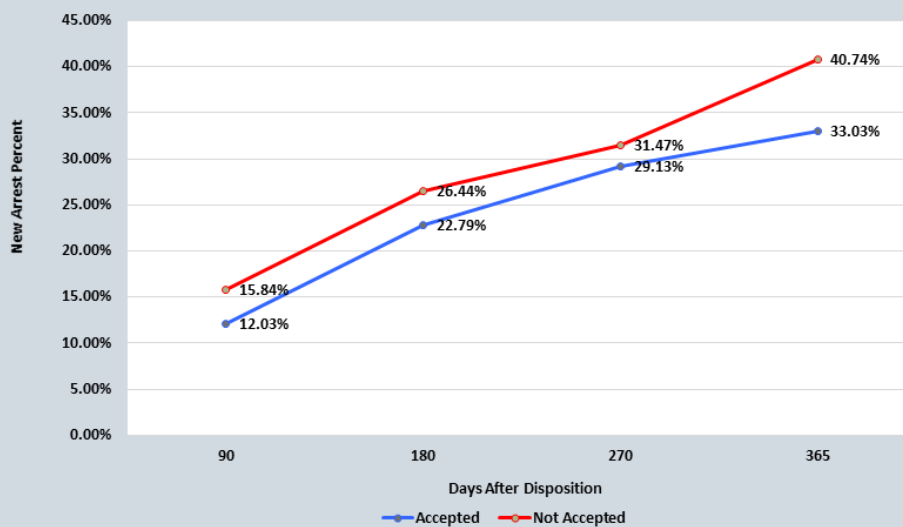


Medication Assisted Treatment

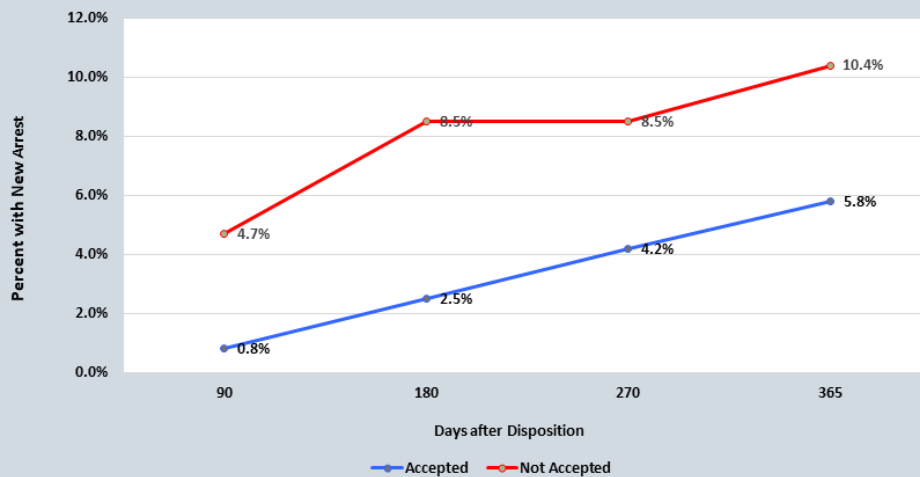


RNP – MCCA Data

New Arrest Rate Post-Disposition, Clients without Incarceration



New Arrest for Drug Charges Post-Disposition, Clients without Incarceration



TPP Program

Bed Days Saved:

- 416 clients served and disposed
- Total Bed Days Saved from release to disposition 74,933
- Total State Savings \$9,666,357 (based on average of \$129 a day).

Summary

- Opiate dependence clients present a greater need for Detox.
- TPP population, has a higher risk of non appearance in court compared to the overall state pretrial population. Incurred only slightly higher rates of FTA and new arrest.
- Clients with an opiate dependence that engaged in MAT treatment had a much higher completion rate than clients who did not engage in MAT.
- Less than a quarter of all TPP clients with disposed cases were given a sentence that included a period of incarceration time.

Appendix C. Presentation by DMHAS on the Substance Use Service System

DMHAS Substance Use Service System

Task Force to Study the Feasibility of
Establishing Opioid Intervention Courts

October 17, 2018

DMHAS-Funded SU Bed Capacity and Utilization

Level of Care	# Beds
Medically Managed Inpatient Detoxification	41
Medically Monitored Intensive Residential Detox	142
Intensive Residential Treatment (DMHAS hospital; 15-30 days)	111
Intensive Residential Treatment (15-30 days)	148
Intensive Residential Co-Occurring Enhanced Treatment (SU + Moderate-Serious MI)	56
Intermediate Residential Treatment 3.5 (including for pregnant and parenting women)	323
Long term Residential Treatment (6-9 months)	50

CT DMHAS Bed Availability

<http://www.ctaddictionservices.com/>



Connecticut Department of Mental Health and Addiction Services
Addiction Services Bed Availability

[home](#) [about](#) [faq](#) [links](#)

Disclaimer: This website is for information only. Admission is not guaranteed even if availability is reported on this site. Call a program and complete their initial screening process for admission. **Note:** If a program shows no open beds, please call for waitlist options.

[Detox Programs](#) [Residential Treatment](#) [Recovery Houses](#)

Detox Programs	City	Phone	Open	As of
Medically managed detox				
CT Valley Hospital (CVH) - Blue Hills Hospital Detox	Hartford	860-293-6400	2	2:49 pm
CT Valley Hospital (CVH) - Merritt Hall Detox	Middletown	800-828-3396 x5	0	8:16 am
Medically monitored detox				
Cornell Scott Hill Health Center - South Central Rehabilitation Center (SCRC) Detox	New Haven	203-503-3639	3	7:27 am
InterCommunity - Residential Detox	Hartford	860-569-5900 x515	2	11:28 am
MCCA - Residential Detox	Danbury	203-792-4515	0	9:56 am
Recovery Network of Programs (RNP) - First Step Detox	Bridgeport	203-416-1915	1	10/11
Rushford - Residential Detox	Middletown	877-577-3233	0	8:46 am
Southeastern Council on Alcoholism and Drug Dependence (SCADD) - Residential Detox	New London	860-447-1717	0	8:01 am

For questions or comments please contact DMHAS at 860-418-6946



65,693 Admissions to All Licensed SU Programs SFY 18*

Program Type	Number
Detox	15,641
Residential Treatment	3,354
Partial Hospital Program (PHP)	4,568
Intensive Outpatient (IOP)	11,437
Outpatient	20,767
Medication assisted treatment (MAT)	9,926

* DMHAS-funded and non-DMHAS-funded

12,057 Admissions to Other SU Programs SFY 18

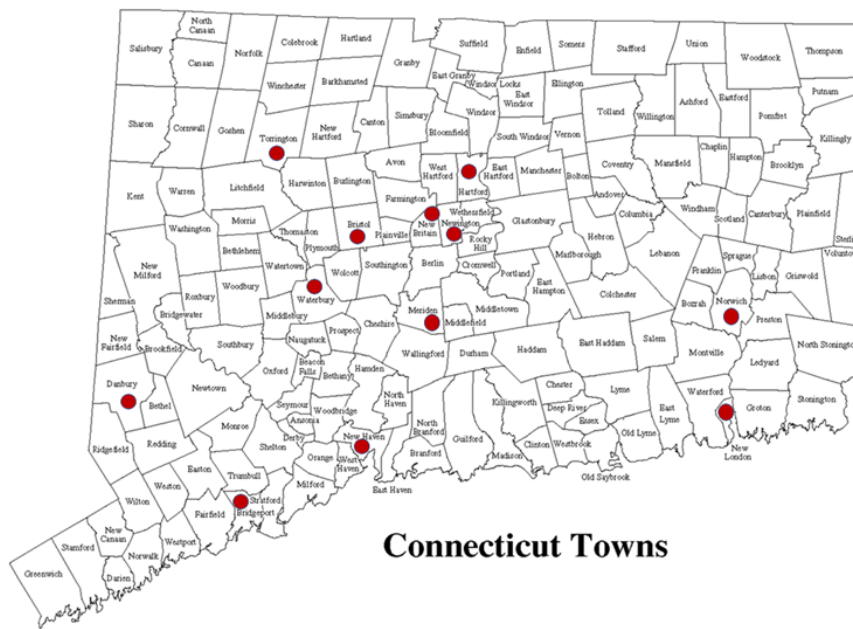
Includes:

- Case management
- Employment services
- Drug/alcohol education

Unduplicated Individuals Served in DMHAS-funded Programs

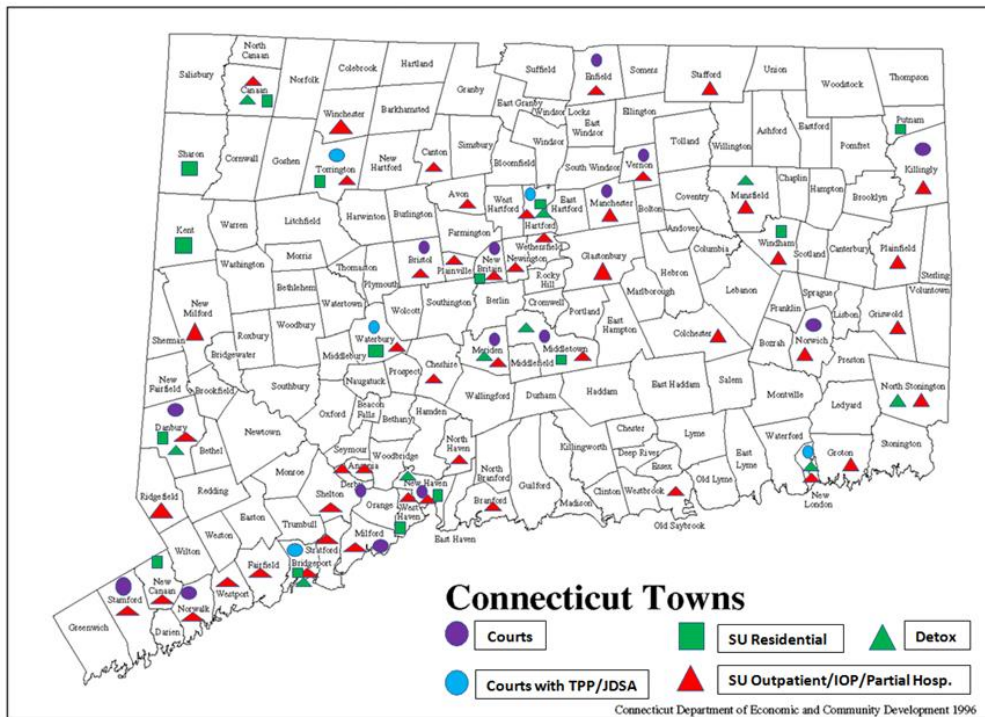
Program Type	Number
Substance Use (SU) programs	51,548
Mental Health (MH) programs	49,590
SU and MH programs	7,094
Total	108,232

Locations with Highest Opioid Overdose Deaths and Opioid Treatment Admission SFY18

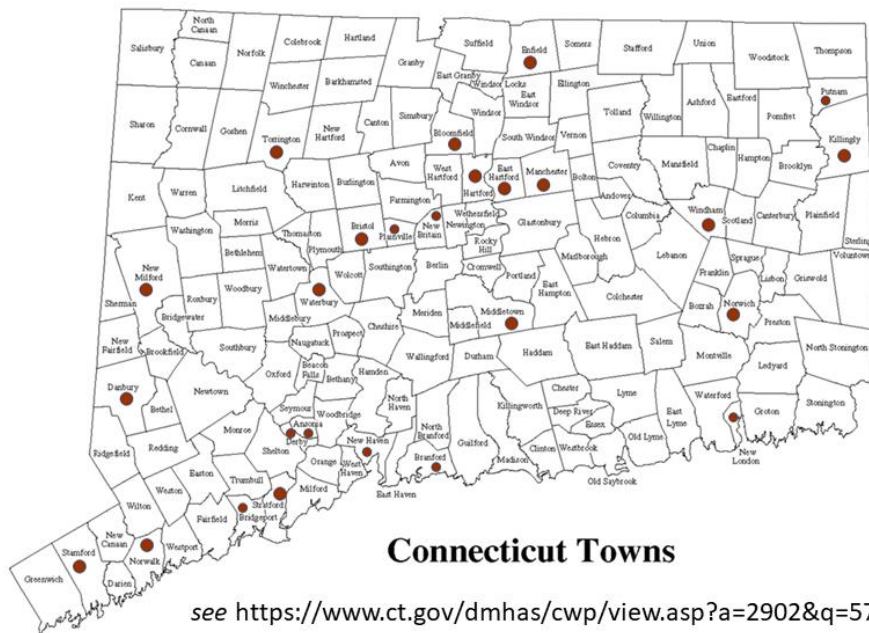


Connecticut Department of Economic and Community Development 1996

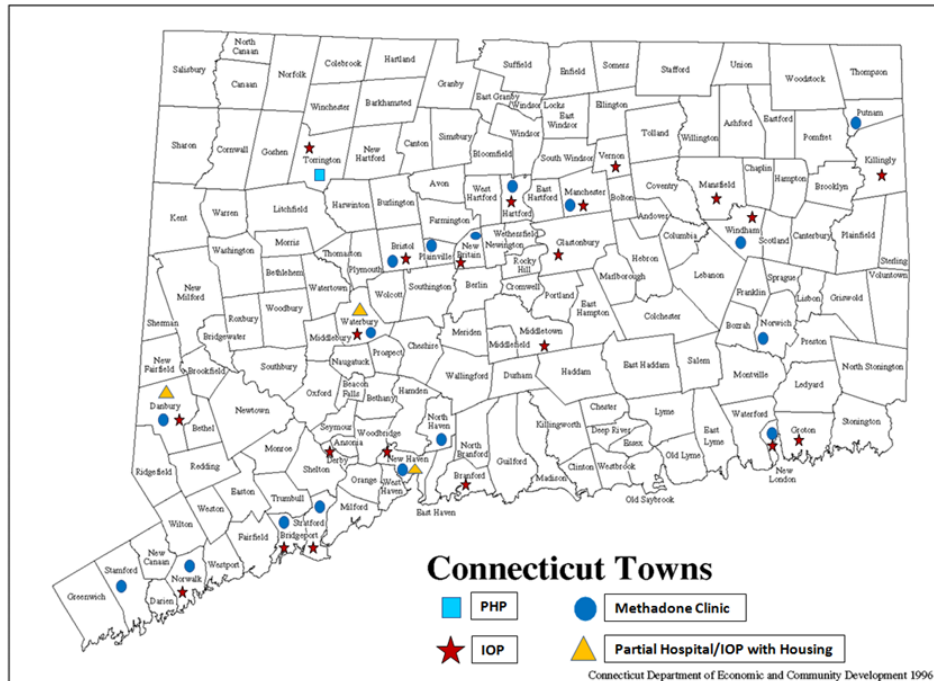
Licensed SU Treatment Services



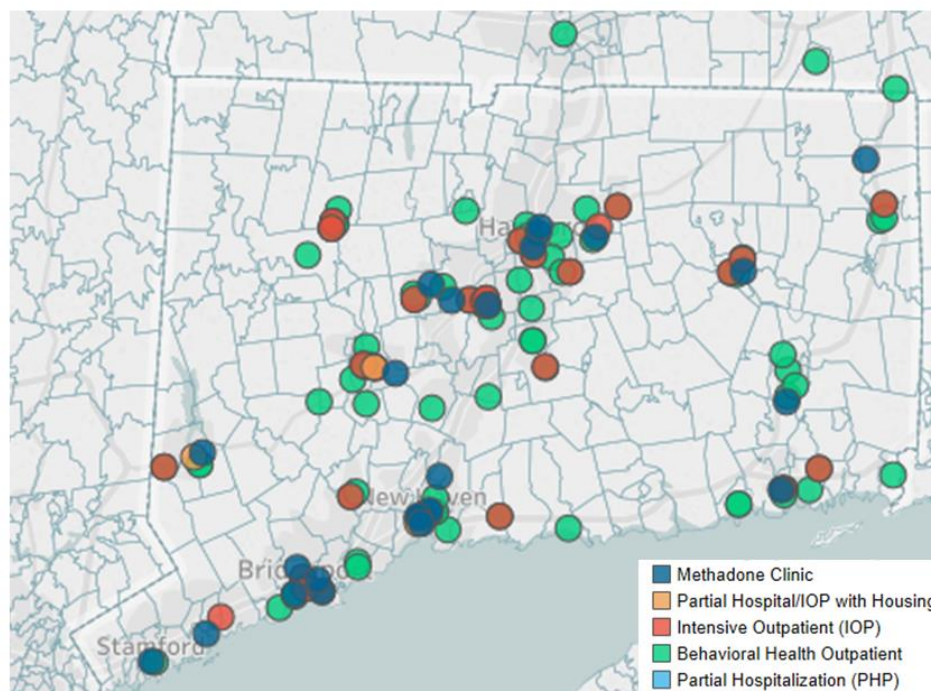
Substance Use Walk-In Assessment Centers



Licensed Medication Assisted Treatment (MAT)



Licensed Medication Assisted Treatment (MAT)



Licensed MAT

Interactive map from previous slide available at:

https://public.tableau.com/views/CTBHPMedicalMATProviderMap/TreatmentProviders?:embed=y&:display_count=yes&:showVizHome=no

MAT for Opioid Use Disorders

Medication	Effects	Criminal Justice Study Results
Methadone	Prevents withdrawal w/o causing euphoria Lowers craving	Decreased drug use Increased participation in addiction treatment Decreased criminal recidivism
Buprenorphine	Suppresses withdrawal and cravings Weak euphoria not enhanced with higher dose Lowers potential for misuse	Increased participation in addiction treatment
Naltrexone	Blocks effects of opioids Rescue from overdose Available as once/month injection (Vivitrol)	
Suboxone is combination of buprenorphine and naltrexone; the latter lowers potential for misuse		

MAT for Alcohol Use Disorders

Medication	Effects
Disulfiram (Antabuse)	When taken with alcohol, causes nausea/vomiting, palpitations, flushing Acts as deterrent to drinking
Naltrexone	Blocks opiate receptors Lowers reward and craving Available as once/month injection (Vivitrol)
Acamprosate	Stabilizes chemical signals in brain disrupted by chronic alcohol use Helps maintain abstinence in combination with therapy/supports

Guidelines for MAT in Jails Released October 15, 2018

- Joint project of the National Commission on Correctional Health Care (NCCHC) and the National Sheriffs' Association (NSA)
- 44 page in-depth review of best practices, models, tools, and references
- Available at:

<https://www.ncchc.org/filebin/Resources/Jail-Based-MAT-PPG-web.pdf>

DMHAS Substance Use & Mental Health Services by GA Court

Programs for Adults with Mental Illness and/or Substance Use Disorders	COURTS									
	GA1 Stamford	GA2 Bridgeport TPP ¹	GA3 Danbury	GA4 Waterbury TPP ¹	GA5 Derby	GA7 Meriden	GA9 Middletown	GA10 New London TPP ¹	GA11 Danielson	
Substance Use Disorders										
Alternative Drug Intervention (ADI)(Men)										
Jail Diversion Substance Abuse (JDSA)										
Jail Diversion Veterans (JDVets)							✓	✓		
Woman's Jail Diversion (JDW)										
Alcohol Education Program CGS 54-56g	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Drug Education Program CGS 54-56i	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Mental Illness and Substance Use Disorders										
Advanced Supervision and Intervention Support Team (ASIST) (Collaboration of CSSD, DOC, and DMHAS)		✓		✓			✓	✓ ²	✓	
Community Recovery Engagement Support and Treatment (CREST)										
Mental Health and Jail Diversion Transitional Housing	✓	✓	✓	✓				✓		
Mental Health Jail Diversion	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Sierra Center Pretrial Transitional Residential Program	✓	✓	✓	✓	✓	✓	✓	✓	✓	

1: TPP is a CSSD Program. Waterbury, New London, and Torrington are funded by DMHAS federal grant.

2: Not active. Attempting to secure provider.

DMHAS Substance Use & Mental Health Services by GA Court (cont'd)

Programs for Adults with Mental Illness and/or Substance Use Disorders	COURTS											
	GA12 Manchester	GA13 Enfield	GA14 Hartford/ Community Court	GA15 New Britain	G17 Bristol	GA18 Torrington Tpp ¹	GA19 Rockville	GA20 Norwalk	GA21 Norwich	GA22 Milford	GA23 New Haven	
<u>Substance Use Disorders</u>												
Alternative Drug Intervention (ADI)(Men)											✓	
Jail Diversion Substance Abuse (JDSA)			✓									
Jail Diversion Veterans (JDVets)									✓			
Woman's Jail Diversion (JDW)				✓	✓						✓	
Alcohol Education Program CGS 54-56g	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Drug Education Program CGS 54-56i	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
<u>Mental Illness and Substance Use Disorders</u>												
Advanced Supervision and Intervention Support Team (ASIST) (Collaboration of CSSD, DOC, and DMHAS)	✓		✓	✓							✓	
Community Recovery Engagement Support and Treatment (CREST)											✓	
Mental Health and Jail Diversion Transitional Housing				✓	✓	✓		✓	✓		✓	
Mental Health Jail Diversion	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Sierra Center Pretrial Transitional Residential Program	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

1: TPP is a CSSD Program. Waterbury, New London, and Torrington are funded by DMHAS federal grant.

2: Not active. Attempting to secure provider.

Select Program Descriptions

- ASIST
 - Alternative in the Community (AIC) supervision, case management & clinical services for pretrial defendants, probationers & parolees with moderate to serious MI
- CREST
 - Day reporting center with clinical services, case management, and skill-building for pretrial defendants, probationers & parolees with SMI
- Sierra Pre-Trial
 - Residential with intensive supervision, clinical services, case management, and skill-building for pretrial defendants with SMI

Recent Developments

SAMHSA State Opioid Response (SOR)

Grant: \$22.2 m over FYs '19 & '20

Continues CJ projects started with the earlier SAMHSA State Targeted Response (STR) Opioid Grant

- DOC's Reentry Support Program
- Methadone maintenance and MAT induction at DOC facilities
- CSSD Treatment Program Pathway (TPP)
- Law Enforcement Assisted Diversion (LEAD) initiatives in Hartford and New Haven

SAMHSA SOR Grant

Description and links on DMHAS webpage:

<https://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=605088>

Women's REACH Program (Recovery, Engagement, Access, Coaching & Healing)

As part of the redesign of Project SAFE, DMHAS has developed the Women's REACH program to help provide a blend of substance recovery coaching and case management services

Women's REACH Program

- Services will be provided statewide through programs located in each of the 5 DMHAS regions; anyone can access the services through a “no wrong door” model. Women seeking REACH services do not need to be connected to DCF or court services.
- Women's REACH Navigators are women who have attained their own recovery from a substance use or co-occurring disorder.
- The Navigators will spend the bulk of their time in the community working one on one with clients and establishing community collaborations within the service system (birthing hospitals, behavioral health & medical providers, community resource agencies, recovery supports, etc.).

Conclusions

- We are fortunate to have SU programs distributed throughout the state
 - Includes MAT for opioid use disorders
- Treatment diversion services are available in every court
- SAMHSA State Opioid Response (SOR) Grant will continue to support programs serving the criminal justice system as well as communities

Questions

Appendix D. A National Review of Opioid Intervention Courts

OPIOID INTERVENTION COURTS: A NATIONAL REVIEW



JUDICIAL BRANCH
OCTOBER 17, 2018

INTRODUCTION

- OPIOID INTERVENTION COURTS ARE A RECENT AND EXPERIMENTAL RESPONSE TO THE NATIONAL OPIOID CRISIS.
- THE COURTS ARE:
 - FOCUSED ON DEFENDANTS WHO ARE AT HIGH RISK FOR AN OPIOID OVERDOSE.
 - BASED ON THE DRUG COURT MODEL OF REHABILITATING DRUG OFFENDERS AND TEACHING ACCOUNTABILITY.
 - ✦ THIS MODEL HAS BEEN UTILIZED FOR ALMOST 30 YEARS.
 - ✦ AS OF JUNE 2015, IT WAS ESTIMATED THAT THERE WERE OVER 3,000 SUCH COURTS NATIONWIDE.

THE BUFFALO EXPERIMENT



- THE FIRST OPIOID INTERVENTION COURT WAS ESTABLISHED IN BUFFALO, NEW YORK, IN MAY 2017.
 - THE COURT IS FUNDED, IN PART, BY A THREE-YEAR, \$300,000 GRANT FROM THE FEDERAL BUREAU OF JUSTICE ASSISTANCE.
 - ✦ THE GRANT SUPPORTS IMMEDIATE, TARGETED, AND INTENSIVE DRUG TREATMENT SERVICES PROVIDED BY PHYSICIANS AND CASE WORKERS FROM THE UNIVERSITY AT BUFFALO'S FAMILY MEDICINE ADDICTION CLINIC.

THE BUFFALO EXPERIMENT CONT'D



- THE CASE MANAGERS:
 - PROVIDE BEHAVIORAL THERAPY AND COUNSELING;
 - ENFORCE CURFEWS;
 - PERFORM WELLNESS CHECKS; AND
 - TRANSPORT PARTICIPANTS TO COURT APPEARANCES.

THE BUFFALO EXPERIMENT CONT'D



- PARTICIPANTS, WHO ARE CONFINED AND NON-VIOLENT, ARE SCREENED BY COURT PERSONNEL FOR SUITABILITY BEFORE ARRAIGNMENT.
- CRITERIA INCLUDE:
 - SCREENING POSITIVE FOR OPIOIDS; AND
 - BEING DEEMED AT RISK OF OVERDOSE OR ADDICTION.

THE BUFFALO EXPERIMENT CONT'D



- PROSECUTION OF PARTICIPANTS IS TEMPORARILY DELAYED AT ARRAIGNMENT AND THE PARTICIPANTS ARE LINKED TO MEDICATION-ASSISTED OUTPATIENT TREATMENT FOR UP TO 90 DAYS.
 - SUCCESSFUL PARTICIPANTS MAY HAVE THE CHARGES DISMISSED.
- TREATMENT PLACEMENT IS COMPLETED, WITH FEW EXCEPTIONS, WITHIN 48 HOURS OF ARREST.

THE BUFFALO EXPERIMENT CONT'D



- THE PROGRAM REQUIRES PARTICIPANTS, WHO ARE RELEASED TO OUTPATIENT TREATMENT AFTER ARRAIGNMENT, TO:
 - UNDERGO INTENSIVE MONITORING BY TREATMENT CASE WORKERS; AND
 - REPORT TO COURT EACH WEEKDAY FOR 90 DAYS.
 - ✦ DURING EACH APPEARANCE, CASES WORKERS AND COURT PERSONNEL:
 - SCREEN PARTICIPANTS FOR DRUG USE; AND
 - PROVIDE CURFEW COMPLIANCE AND HOME VISIT REPORTS.
 - ON WEEKENDS, THE PARTICIPANTS ARE MONITORED BY COURT PERSONNEL VIA TELEPHONE CONTACT AND OCCASIONAL HOME VISITS.

THE BUFFALO EXPERIMENT CONT'D



- AFTER COMPLETION OF THE INTENSIVE PHASE OF THE PROGRAM, A PLEA BARGAIN IS GENERALLY NEGOTIATED AND THE PARTICIPANT'S CASE IS CONTINUED FOR WEEKLY COURT MONITORING.
- AT THIS POINT, SOME PARTICIPANTS HAVE LEFT THE PROGRAM BECAUSE A PLEA AGREEMENT COULD NOT BE REACHED OR THE PARTICIPANT HAS BEEN SENTENCED.

THE BUFFALO EXPERIMENT CONT'D



- IN JUNE 2018, DURING A MEETING OF THE NATIONAL JUDICIAL OPIOID TASK FORCE, PRELIMINARY OUTCOME DATA FROM THE BUFFALO OPIOID INTERVENTION COURT WAS PRESENTED:
 - 250 DEFENDANTS HAVE PARTICIPATED IN THE PROGRAM;
 - 138 ARE CURRENTLY ACTIVE;
 - 109 HAVE SUCCESSFULLY COMPLETED THE PROGRAM; AND
 - 3 HAVE COMPLETED THE PROGRAM, BUT HAVE SUBSEQUENTLY DIED FROM AN OVERDOSE.

THE BUFFALO EXPERIMENT CONT'D



- IN A REVIEW OF THE PROGRAM, JANET DIFIORE, CHIEF JUDGE, NEW YORK COURT OF APPEALS, NOTED THE COURT'S SUCCESSES, BUT DID CAUTION THAT:
 - "THE BUFFALO OPIOID INTERVENTION COURT REFLECTS A RESOURCE-INTENSIVE APPROACH THAT MAY BE HARD FOR SOME JURISDICTIONS TO REPLICATE GIVEN THE MANY BEHAVIORAL HEALTH AND COURT PERSONNEL REQUIRED TO MANAGE AND EXECUTE THE MULTIPLE ASPECTS OF THE PROGRAM."

OTHER INTERVENTIONS

- A SIMILAR MODEL TO THE BUFFALO OPIOID INTERVENTION COURT HAS BEEN ESTABLISHED IN CUMBERLAND COUNTY, PENNSYLVANIA.
 - OUTCOME DATA IS UNAVAILABLE.
- IN BRONX COUNTY, NEW YORK, DEFENDANTS CHARGED WITH MISDEMEANOR DRUG POSSESSION CHARGES AND AT HIGH RISK FOR OPIOID OVERDOSE ARE DIVERTED TO A SPECIALIZED CASE TRACK, THE OVERDOSE AVOIDANCE AND RECOVERY TRACK.
 - SUCCESSFUL COMPLETION OF THE TRACK RESULTS IN THE CASE BEING DISMISSED.
 - OUTCOME DATA IS UNAVAILABLE, BUT THERE ARE PLANS TO EXPAND THIS MODEL THROUGHOUT NEW YORK CITY.

CONNECTICUT'S DRUG INTERVENTION COURTS

- CONNECTICUT CURRENTLY HAS TWO “DRUG COURTS”, DANIELSON AND NEW HAVEN.
 - BOTH WERE INSTITUTED IN 2004.
 - THE LENGTH OF THE PROGRAM IS GENERALLY 12 TO 15 MONTHS.
 - ✦ IN 2018 THERE HAVE BEEN FIVE PARTICIPANTS IN DANIELSON AND 19 PARTICIPANTS IN NEW HAVEN.
 - THE COMPLETION RATE FOR DANIELSON IS 52 PERCENT.
 - THE COMPLETION RATE FOR NEW HAVEN IS 55 PERCENT.
 - OF THOSE COMPLETERS, THE RECIDIVISM RATE WITHIN THREE YEARS OF COMPLETION, IS:
 - ✦ DANIELSON, 46 PERCENT; AND
 - ✦ NEW HAVEN, 71 PERCENT.

SOURCES



- BUFFALO OPIOID INTERVENTION COURT, INTERVIEW: BROOKE CROUSE, CASE MANAGER
- NATIONAL CENTER FOR STATE COURTS
- NATIONAL INSTITUTE OF JUSTICE
- NEW YORK COURTS.GOV
- OFFICE OF JUSTICE PROGRAMS
- PENNSYLVANIA PUBLIC BROADCASTING
- THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS
- UNIVERSITY AT BUFFALO, SCHOOL OF MEDICINE